

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008969
STATE FILE NUMBER

FILED APR 8 1959

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sullivan Mo.		c. CITY OR TOWN Sullivan Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Olson Rest Home		d. STREET ADDRESS (If outside, give location) Daniel St.	
3. NAME OF DECEASED (Type or print) First Middle Last Wilhelm John Wandersee		4. DATE OF DEATH Month Day Year March 30 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Ben Mo.
13a. FATHER'S NAME Fred Wandersee		13b. MOTHER'S MAIDEN NAME Ernestine Porter	14. NAME OF HUSBAND OR WIFE unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 493-10-4902	17. INFORMANT Address Mrs Wm Elder St. James Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) CEREBRAL THROMBOSIS, RECURRENT DUE TO (c) ARTERIO SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X			INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 3 YRS YEARS
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Death occurred at 1954 10:40 to Mar 30 1959 and last saw him alive on Mar 30 1959		22. SIGNATURE (Degree or title) MO. ADDRESS Sullivan Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE April 2 1959	23c. NAME OF CEMETERY OR CREMATORY Ben Cemetery	23d. LOCATION (City, town, or county) (State) Ben Mo.
24. FUNERAL DIRECTOR ADDRESS Norman Hoener Cuba Mo.		25. DATE RECD. BY LOCAL REG. 3/31/59	26. REGISTRAR'S SIGNATURE Thomas A. Humphrey

(Licensed Embalmers Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

3951 3 287

APR 9 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed W. P. Sheffer

Licensed Embalmer No. 2692

P. O. Address Sullivan m

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.